Indiana State Department of Health
Early Hearing Detection and Intervention Program

Outpatient Screen (or Re-Screen) Report

Birthing Hospital:_____

Infant Name:_____
First Middle Last

Medical Record Number (MRN):_____ DOB:_____

Mother Name:_____
First Middle Last

PCP Name:_____ PCP Phone #:_____

Date of Initial Screen:_____

Date of Outpatient Screen:_____

Outpatient Screen Results:

Right Ear: Pass Refer

Left Ear: Pass Refer

Risk Factor: Yes No Specify:_____

If infant did not pass:

Diagnostic test scheduled? Yes No

Location of diagnostic test:_____

Date of diagnostic test:_____

☐ **This infant did not return for the scheduled outpatient re-screen.**

Return this form to the ISDH EHDI Program at:

CDHHE – Raney Hall
1200 E. 42nd St.
Indianapolis, IN 46205
mgallien@isdh.in.gov
Fax: 317-925-2888